System Affordability Standards for Health Insurers in Rhode Island

Tracking and Monitoring Progress

for discussion with HIAC

Tuesday, January 19th, 2010

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Reminder: OHIC Affordability Standards

Standards apply to Commercial Insurers in RI (Developed by HIAC in 2008/2009)

1. Health plans **will increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years**. This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.

2. As part of the increased primary care spend, **health plans will promote the expansion of the CSI-Rhode Island project or an alternative all payer medical home model with a chronic care focus** by at least *25 physicians in the coming year*[1] and

3. Health plans will promote EMR incentive programs that meet or exceed a minimum value.

4. Health plans commit to **participation in a broader payment reform initiative** as convened by public officials in the future.

(1) Italicized language was refined in September 09, # new participating docs increased from 15 to 25

2010 Carrier Commitments

Primary Care Spending Commitments

	BCBSRI	United	Blended
2008 Baseline %	5.8%	5.4%	5.8%
2010 Targeted Spend	6.8%	6.4%	6.8%
2010 Estimated Investment*	$9 Million	$2 Million	$11 Million

Estimates based on projected trend and total medical expenditures by carrier. Estimates will be revised semi-annually based on latest trend and medical expenditure data

Additional Commitments
(Affordability Standards Two and Three, Used for Projecting Spend for Standard One)

1. CSI Project expansion, additional 25 PCPs, as of 4/1/2010
2. Participate in design of ED incentive program, for 1/1/2011 implementation (on hold)
3. Support single coordinated EMR incentive eligibility "test" through RIQI

Note: Tufts will not be held to specific spend, because of small enrollment but has agreed to:

- Proportionate participation in CSI Project
- Implementing EMR adoption incentives
- Measurement of PCP Spend rates

(1) Italicized language is OHIC addition in September 09.

What we have done

- **Planning**
  Finalized carrier investment plans – how they intended to meet the targeted investment

- **Reporting**
  Created and standardized a reporting template for carriers to track primary care spend data. Baseline data has been reported for 2008. Anticipate semi-annual update in April

- **Monitoring**
  Designed and implemented a process for ongoing monitoring of 2010 investments, planning for 2011

- **Evaluation (in process)**
  Developing key metrics, working to capture critical data to track project performance

Planning

Summary of Plans by Health Insurers to Increase Primary Care Spend

Total ($)	Portion	Category
$5.0 M	46%	Patient Centered Medical Home (all payor and plan-specific)
$1.2 M	11%	Electronic Medical Records Incentives
$0.8 M	8%	FFS Fee Improvements
$0.6 M	5%	Loan Repayment
$3.4 M	31%	Other, carrier-specific investments (Pay for Outcomes, Pay for Structure, Benefit changes to increase volume, etc.)
$11.0 M	**100%**	**Total Year 1 Planned Investment, 2010**

(See appendix for details by plan)

Reporting

Carriers have each provided baseline data on primary care spend in accordance with the template below…an update for 2009 will be provided in April

Template 1: Rhode Island Fully Insured Commercial Payment Based on Claims Paid

Calendar Year	2006	2007	2008	2009	2010
RI Primary Care Payments					
Number of visits					
FFS Payment for CPT codes: E&M well visits					
FFS Payment for CPT codes: E&M sick visits					
FFS Payment for CPT codes: other					
Pmpm incentive payments					
Lump sum payments (1)					
Additional payments to primary care providers (2)					
Other Allowable payments (3)					
Total Primary Care Payments	$ -	$ -	$ -	$ -	$ -
All RI Medical Payments					
Rx (prior to adjustments)					
Rx (adjustment for carve outs)					
Rx Total	$ -	$ -	$ -	$ -	$ -
MHSA Total					
All Other Medical Payments (exc Rx + MHSA)					
Total RI Medical Payments	$ -	$ -	$ -	$ -	$ -
PC Spend as % of Total					

(1) Italicized language is OHIC addition in September 09.

Monitoring Process

We are holding quarterly update meetings with the carriers, as described below

	2010 Investment Forecast Updates	2011 Budget Development
Oct-09	Review 2010 Carrier Investment Plan (final)	
Jan-10	Review updated 2010 Investment Forecast	
Apr-10	Review updated 2010 Investment Forecast Review 2009 Primary Care Spend Report	Review Preliminary 2011 Investment Plans (no numbers) Review draft estimates of required investment targets (total dollars required to meet spend target)
Jul-10	Review updated 2010 Investment Forecast	Preliminary 2011 Investment Plans (draft numbers)
Oct-10	Review updated 2010 Investment Forecast. Focus on any needed corrective actions Review 2010 YTD Primary Care Spend Report	Final 2011 Investment Plans Due
Jan-11	Review updated 2010 Investment Forecast Focus on any needed corrective actions	Review any updates to 2011 Investment Plan
Apr 2011 Meeting	2010 Primay Care Spend Report Due, reporting actual PC spend as % of total Medical spend	Review updated 2011 Investment Forecast

Note: Quarterly Investment Forecasts and 2011 draft investment plans submitted by the carriers to OHIC will be reviewed regularly with HIAC and PCPAC for feedback and guidance.

Evaluation

We are developing key metrics to track program performance

- **Process Measures**

  Primary Care Spend

  All payor medical home sites, providers, payment

  EMR participating providers, payment

- **Outcome Measures**

  Primary care physician satisfaction

  Primary care supply

  Ambulatory care sensitive conditions: ER visits, hospitalizations

  Medical Trend

Key Metrics (page 1 of 3)

Calendar Year	2006	2007	2008	2009	2010	2011	2012	Source:
Process Measures:								
1. Primary Care Spend								
Total Primary Care Spend								Carrier reporting templates
Total Medical Spend								Semi-Annually in May and Oc
Primary Care % of total		**5.5%**	**5.8%**					
2. All Payor Medical Home Initiative								Carrier Reporting Template
Number of sites		-	5					Semi-Annually in May and Oc
Number of providers		-	30					
$ paid in pmpm incentives		$ -	$ 224,981					
$ paid for Nurse Case Manager		$ -	$ 66,555					
Project management payments		$ -	TBD					
Total	n/a	$ -	$ 291,536	$ -	$ -	$ -	$ -	
3. EMR Incentive Program								Carrier Reporting Template
Blue Cross								Semi-Annually in May and Oc
Participating Professional Providers								
Participating Primary Care Providers								
$ EMR incentive payments								
United								
Participating Professional Providers								
Participating Primary Care Providers								
$ EMR incentive payments	n/a	n/a	n/a					
Tufts								
Participating Professional Providers								
Participating Primary Care Providers (2)								
$ EMR incentive payments (2)	n/a	n/a	n/a					
Total EMR incentive payments (bonus only)								

Key Metrics (page 2 of 3)

Calendar Year		2006	2007	2008	2009	2010	2011	2012	Source:
Outcome Measures:									
Primary Care Physician Satisfaction									OHIC annual provider survey
Q4 How would you rate the adequacy of reimbursement rates paid to you from each health plan									
% good/very good	BCBSRI	n/a	n/a	n/a	38.7%				
% good/very good	United	n/a	n/a	n/a	11.9%				
% good/very good	Tufts	n/a	n/a	n/a	32.8%				
Q5 How much have reimbursement rates paid to you from each health plan improved or worsened from one year ago?									
% improved/improved very much	BCBSRI	n/a	n/a	n/a	46.0%				
% improved/improved very much	United	n/a	n/a	n/a	14.6%				
% improved/improved very much	Tufts	n/a	n/a	n/a	11.1%				
Q8 Beyond payment for specific services provided, do you receive any additional payments such as bonuses, pay for performance, or quality incentives from health plans?									
% Yes		n/a	n/a	n/a	37.3%				
Q9 If yes, how would you rate your level of satisfaction or dissatisfaction with these additional payments									
% good/very good	BCBSRI	n/a	n/a	n/a	60.0%				
% good/very good	United	n/a	n/a	n/a	8.6%				
% good/very good	Tufts	n/a	n/a	n/a	9.1%				
Q10 How would you rate each healt plan's efforts to promote improvements in RI's health care system									
% good/very good	BCBSRI	n/a	n/a	n/a	50.2%				
% good/very good	United	n/a	n/a	n/a	9.2%				
% good/very good	Tufts	n/a	n/a	n/a	11.4%				

Key Metrics (page 3 of 3)

Calendar Year	2006	2007	2008	2009	2010	2011	2012	Source:
2. Primary Care Supply								Carrier Reporting Template
Blue Cross								Semi-Annually in May and Oc
Primary Care Provider Count	862	912	931					
Total Number of Professional Providers	3,008	3076	3,078					
% Primary Care	29%	30%	30%					
United								
Primary Care Provider Count	n/a	924	923					
Total Number of Professional Providers	n/a	2604	2,604					
% Primary Care	n/a	35%	35%					
3. Ambulatory Care Sensitive Conditions (Commercial Only)								Sam V-B, Department of Hea
ER Use								
Total ER visits	165,824	163,689	161,258					
ACS ER visits								
ACS as % of total	0.0%	0.0%	0.0%					
Hospitalizations								
Total visits	50,573	53,472	52,700					
ACS hospitalization								
ACS as % of total	0.0%	0.0%	0.0%					
4. Total Medical Trend								Carrier rate filings?
Overall Rhode Island Medical Trend								
BCBSRI								
United								

* Includes up-front bonus payment only. Fee schedule increases are captured in E&M code payments and will not be tracked

Next Steps

- **Complete quarterly reviews with carriers (January)**

  Updates to investment plans

- **Key Metrics**

  Continue to refine measures for ACS data, medical trend

  Implement provider survey for 2010

- **April review**

  2009 Spend Report (new baseline primary care spend percentages)

  Updated 2010 investment plans (are they on target, mid-course corrections

  Preliminary 2011 Investment plans (no numbers)

  Draft estimates of 2011 investment targets (Dollars required to meet target)

Backup

BCBSRI Investment Plan Detail*

Category	Description	% (Final)
1) Patient-Centered Medica	Funding to support adoption of PCMH. Includes: 1) BCBSRI-only program, focused on complex members, with funding for infrastructure (e.g. nurse case manager) and PMPM payments 2) expansion of CSI-RI program	50.0%
2) Electronic Health Record	Funding to support implementation and use of electronic health records. Includes: 1) funding for pre-implementation readiness assessment for new EHR users 2) funding for new EHR users (including training/implementation support) 3) funding for existing EHR users 4) enhanced fee schedule for qualified providers	10.0%
3) Behavioral Health and Pr	Funding to improve behavioral health access and communication between primary care and behavioral health providers. Includes support for co-location of behavioral health in primary care practices and for the development of collaborative agreements (at least 5 new co-located practices and several collaborative agreements)	5.0%
4) Value-based Benefits	Co-pay waivers to incent use of targeted PCPs	2.5%
5) Delivery System Improvement (Specialist Focus)	Funding for specialist providers to improve coordination with primary care. Includes 1) Enhanced fee schedule for specialist EHR users who coordinate care/communicate w PCPs 2) bonus based on PCP satisfaction with specialist services / care coordination 3) develop principal care centers (specialist "medical homes" - Ex. end stage CHF/Cardiology) 4) lump sum funding for "urgent" access to specialists as alternative to ER/urgicenter	5.0%
6) Delivery System Improvement (Hospital Focus)	Support the development of a patient-centered medical "neighborhood" - new contracts/ initiatives to support care coordination among hospital, specialists , and PCPs [i.e. funding to hospital for NCM who provide care coordination services to multiple local PCP practices]	5.0%
7) Pay for Performance	Incentive to promote more cost effective drug utilization [i.e. therapeutic substitution for cholesterol lowering /PPI drugs] - gainsharing with "non-engaged" PCPs	7.5%
8) Accountable Care Organizations	Incentives [lump sum grants] to encourage the development of accountable care organizations. Examples include: 1) incentives for smaller practices to merge or join larger organizations 2) incentives for quality improvement activities [i.e. educational meetings] 3) incentives for practices to improve access by extending office hours 4) Discharge Care Coordination	5.0%
9) Fee Schedule Increase		5.0%
10) Loan Repayment	Funding available in the Rhode Island Primary Care Educational Loan Repayment Program	5.0%
		100.0%

*The programs listed here are subject to implementation. Actual spending may differ from projected because of change in program details, changes in implementation, or variation in number of providers who meet standards of program. Health plans will be held accountable for achieving overall primary care spend rate targets.

UHC Investment Plan Detail*

Investment Plan Detail	Description	Revised 10/13/09
Structure and Process Incentives:		**45%**
CSI All payer medical home	Health plans commit to establish a NCQA certified Medical Home and commit to supporting an expansion of either the Rhode Island Chronic Care Sustainability Initiative or an alternative all payer medical home model. THealth plans commit to establish a NCQA certified Medical Home and commit to supporting an expansion of either the Rhode Island Chronic Care Sustainability Initiative or an alternative all payer medical home model. As directed by the health insurance commissioners office, UHC assumed that the CSI project will increase by 25 PCP FTEs effective 4/1/10.	25%
EMR Incentive Programs	Health plans to commit to implementation of a certified electronic medical record (i.e. certification by the Commission for Healthcare Information Technology (CCHIT) physician primary care and/or specialty care EMR adoption incentive that pays: (i.e. United: $2,500 or more, up to a practice maximum of $7,500) in bonus in the form of pay-for-participation payments equal to $.60 PMPM or in increased fees, totaling in value at least 3% great than the insurer's standard fee schedule.	13%
Primary Care QTIAC Requests	UHC Quality and Technology Investment Advisory Council (QTIAC) consists of constituents who guide and participate in the selection of community quality and technology health care initiatives based on projects' value to the health care community, including its value to providers, employer and consumers of the RI health care system. QTIAC will invest in certain primary care initiatives such as Loan Forgiveness, RICCC, and others.	7%
Outcomes Incentives:		**30%**
Pay for Performance	Practice Rewards - a United Healthcare National program that offers financial recognition for physicians who have met the highest quality and cost efficiency criteria under the United Health Premium Designation program. A 5% fee schedule differential recognizes physicians who meet or exceed guidelines for quality and cost efficient care. A 3% fee schedule differential recognizes those physicians and facilities who have shown improvement from the previous year (this is new for 2010). United expects more will be paid under this program in 2010 as more physicians exceed guidelines and for the new improvement program	25%
After hours Incentives	Additional payment to physicians who offer extended hours or provide services in office to their patients resulting in lower ER visits and other cost savings advantages	5%
Fee Schedule, bonus enhancements and volume enhancements:		**25%**
Shift of Services	Plan design changes currently under review expected to shift utilization to PCP offices	5%
Vaccine Administration	Increase in physician and flu clinic administration fees.	20%
		100%

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January 12, 2010

Hello to all,

I've limited this e-mail to just a relatively small handful. As each of you know, I'm in the midst of the very significant challenge of recruiting a new family physician (or med/peds doc) to join me when Dr. Moran retires this summer. We've all spoken at great length about the importance of appropriate funding/ reimbursement for primary care. And we're all extremely familiar with the directive from the Health Commissioner's office re: increasing funding for primary care.

I understand the demand that increased $ cannot simply go to increased reimbursement for E&M codes. I believe it's crucial that we revisit that. Not one of the twelve graduating Family Medicine residents from Brown's program is staying in Rhode Island. Several are moving directly across the border into Mass. Only one of the med/peds graduating chief residents is staying in Rhode Island. His wife is currently working (as a physician) in Mass. They do not have children and as a 2 physician family can probably afford to stay in RI.

The current average salaries for Family Physicians here in Rhode Island is painfully too little. It's almost laughable. Last week I received two solicitations for primary care physicians in New England. Admittedly, I don't know where in NE. Nonetheless, the STARTING salaries for both around $185K (plus $20K signing bonus) with a reasonable possibility that the additional productivity bonuses would bring the ($185K) salary to well over$200K per year.

Within the University Medicine foundation, we've had to begin by offering guaranteed salaries for 2 years, at levels far above the current salaries of most of the PCPs in the Foundation already. Those already here, have been in practice for many years and would be extremley upset if they knew that a new recruit was making more than they were. We're all concerned to hear of these other solicitations for such high salaries. Admittedly, perhaps there's a lot in the small print that is not immediately evident in the recruiter's brochure. Nonetheless, the $ offers are much, much higher than anything in Rhode Island.

All that said, it's too little, too late, too simplistic to think that by increasing reimbursement largely tied to the extremely onerous (I know because my office is "going live" today) job of incorporating an EMR– we will significantly ameliorate the primary care crisis. It will address some of the issues and I can see that a functioning EMR holds out the possibility of enhancing the quality of care in certain ways.

I strongly advise that a significant amount of the Health Commissioner's call for an increased primary care spend go directly to increasing the E&M reimbursement. This element of primary care reimbursement is both crucial and urgent.

It may be important to look to other markets to see how it is that they do this. Have they already adjusted their relative reimbursements to PCPs vs specialists? Do they have smaller reserves? Do they pay lower salaries to their staff or have less luxious benefits? I have absolutely no idea. But, suffice it to say, without the expectation of a higher "fair" reimbursement we cannot hope to recruit new PCPs to the state. Even though RI is a beautiful state with much to commend it, I have spent the last 5+ months searching for a new Family Medicine recruit. So far, I have had only ONE out of state physician come to interview for the position. I am hoping to have another one within the next several weeks.

I believe that the situation is desperate and calls for thinking further out of the box than we have so far. I do not think I am over-reacting. Additional reimbursement tied to "improved performance" or "enhanced/meaningful use of an EMR" is fine. It will not, however, adequately address the problem of supply and access to primary care for the citizens of our great state. Nor, given our already stretched work-force, will we do that by increasing the reimbursement for off-hours access.

If you feel that others should read this, I would be only too pleased for you to distribute it, or let me know. I would be happy to send it around. If you believe I'm way off the mark, please let me know that as well. The necessary increase in reimbursement is the elephant in the room. At this point, we must increase the E&M reimbursement for nothing other than being a primary care physician in Rhode Island. Perhaps silly, but true. We must speak to this more directly.

Wishing us all a lot of success at solving the primary care problem.
Michael Felder, DO, MA, FAAFP